

The use of anaesthesia to diagnose malingering in the 19th century

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INTRODUCTION

Malingering is the purposeful simulation or exaggeration of mental or physical illness in order to gain some end. Soon after anaesthesia was introduced ether, and then chloroform, were used to assist in the detection of suspected malingerers. This raised diagnostic issues, some of which were not understood or appreciated at the time. It also raised ethical concerns, attitudes to which were often very different from those which might be expected among modern doctors. In the 19th century malingering was seen most commonly among soldiers and it is with them that this paper is chiefly concerned.

FRANCE AND BRITAIN

On 8 March 1847, within a few months of the introduction of etherization, the French surgeon Jean Baptiste Lucien Baudens described its use to distinguish feigned from real disease in two soldiers.¹ One had a spinal curvature which disappeared under the effect of ether and he was therefore diagnosed as a malingerer. The other had a complete ankylosis of the hip joint which was thought to be feigned but which was proved genuine when it persisted under full etherization. In a lecture to the medical members of the United Service Institution in May 1847, John Snow described Baudens' cases as an example of how ether could be used to assist in the diagnosis of difficult cases of malingering.² In August 1847 Spencer Wells, who at that time was a surgeon with the Royal Navy in Malta, described his experience with the inhalation of ether in 106 cases, one of which was a case of suspected malingering but he gave no details of this patient.³ In the next year Monsieur Fix, a surgeon in the French army, claimed to be able to distinguish between real epilepsy and feigned fits because he believed, erroneously, that chloroform would induce a fit in patients with genuine epilepsy.⁴

In Britain the use of chloroform for the detection of malingerers was recommended in 1852 by George Ballingall, the Regius Professor of Military Medicine in Edinburgh, in his textbook of military surgery⁵ and 4 years

later, at the end of the Crimean War, another Edinburgh surgeon, George Macleod, endorsed its use with the claim that the detection of feigned disease was now 'a matter of simplicity' for military surgeons.⁶ The use of anaesthesia to detect malingerers in the British army continued in regular use for at least another two decades⁷ and was still sometimes used during the First World War.⁸

AMERICA

The use of ether to detect a military malingerer in America was first authorized in 1849, the case involving an apparently immobile knee joint which flexed readily when the soldier was anaesthetized.⁹

Malingering became extremely common during the American Civil War of 1861–65, partly because a bounty of \$300 or even more was paid to each volunteer.¹⁰ A new recruit who could get himself discharged by faking illness could then obtain another bounty by enlisting elsewhere. The use of anaesthesia to assist in the detection of feigned illness was recommended in manuals published during the war by both Union¹¹ and Confederate¹² surgeons. Indeed the Regulations for the Government of the Bureau of the Provost Marshal General, issued in 1863, required that 'impaired motion of joints and contraction of limbs . . . in which the nutrition of the limb is not manifestly impaired, are to be proved while in a state of anaesthesia induced by ether only'.¹³

The doctors who gained the most experience in the detection of malingering and the use of anaesthesia for this purpose were probably William Keen, George Morehouse and Silas Weir Mitchell who worked at Turner's Lane Hospital in Philadelphia.¹⁴ They used etherization to assist in the detection of malingerers feigning illness due to joint contractures, spinal deformities, aphonia, deafness, blindness, paralysis, epilepsy and urethral stricture. In some of these, for example joint contractures and urethral strictures, the diagnosis would be made while the patient was fully anaesthetized; in others the patient would be induced to give himself away as he went under the influence or as he was surfacing from the effects of the ether. Keen and his colleagues appear to have had considerable faith in their ability to distinguish between feigned and genuine illness using anaesthesia. As will be discussed later, this faith

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was certainly not justified, but they did recognize one potential pitfall. It was, they emphasized, essential to push the ether to the point of complete anaesthesia because it was not unknown for malingerers to escape detection by simulating the effects of ether so that they were never properly under its influence.

ETHICAL AND DIAGNOSTIC ISSUES

The use of anaesthesia to detect malingerers raised a number of ethical and diagnostic issues which were discussed in a paper published in 1849 by a French doctor, Monsieur Bayard.¹⁵ Bayard started by challenging the hypothesis that because a joint contracture disappeared under anaesthesia it must necessarily have been feigned. He also disapproved of the use of anaesthesia to induce involuntary revelations, pointing out that these might be wholly inaccurate and should not, therefore, have any legal standing. He argued that anaesthesia should only be used if the person under suspicion gave his free consent after he had first been informed of the possible consequences of the procedure and that, even if informed consent had been given, the doctor should still remain liable for any toxic effects of the anaesthetic. *The British and Foreign Medico-Chirurgical Review* of October 1849 agreed that anaesthesia should not be used to detect malingerers, partly because there were occasional fatalities with chloroform and partly because there was uncertainty about the accuracy of the technique.¹⁶

When Monsieur Bayard and *The British and Foreign Medico-Chirurgical Review* questioned the diagnostic accuracy of anaesthesia as a test for feigned diseases, they did so purely in terms of other physical or organic diagnoses. For most of the 19th century doctors believed in a concept of dualism which held that the mind and the body were separate entities. The differential diagnosis of a joint contracture or of a paralysis was seen in terms of black or white; the black of wilful malingering or the white of genuine organic disease. Weir Mitchell was one of the first to reject the concept of dualism, in his case for a paradigm in which the emotions and physical symptoms were inseparably intertwined, but his thinking in these matters was restricted 'by his tendency to blur moral turpitude with mental disorders',¹⁷ a tendency which may have been nurtured by what he would have perceived as the moral turpitude of the malingerers he came across during the Civil War. It was not until the 1880s that Charcot, building on the earlier work of English doctors from Brodie in 1837 to Paget in 1873 and Page in 1883, established the concept of the traumatic or post-traumatic neurosis as an independent nosological entity,¹⁸ and it was another decade before Freud and others were to develop concepts of unconscious mentation, hysterical conversion and secondary gain.¹⁹ As

Richard Asher was to write in his essay on malingering a century later, the diagnosis of malingering 'must not be made for the sole reason that the clinical picture is not yet hung in the clinical picture gallery of the doctor in charge. It may be something he hasn't heard of'.²⁰

The distinction between malingering and hysterical conversion was still not always appreciated during the First World War, and for some of those who did recognize a difference it could be an arbitrary or theoretical distinction which was not considered to be of any practical relevance. For example, when Milligan described treatment by suggestion while under the partial influence of chloroform as a therapy for 'shell-shock', he was careful to exclude all cases with 'discoverable organic lesions' but he included cases of both genuine hysteria and conscious fraud because both, he claimed, responded to his treatment.²¹

Both Bayard¹⁵ and *The British and Foreign Medico-Chirurgical Review*¹⁶ criticized the use of anaesthesia to detect malingerers because of the risk of a fatal outcome. This is certainly an ethical issue but perhaps, when viewed in comparison with the risk of death from other causes in the mid-19th century and especially those faced by a soldier on active service, it may have been regarded as too small a risk to merit much consideration. It would certainly have been regarded by those under suspicion as vastly preferable to some of the other diagnostic methods then in use. Some surgeons in the American Civil War advocated using the actual cautery.^{11,12} Others used strong galvanic currents¹⁴ as did also at least one English prison doctor.²² We are conditioned to hear of barbaric tortures being used to investigate mediaeval witchcraft or to extract confessions from modern day political detainees but it is still disturbing to read of their use by otherwise respectable doctors in the post-Enlightenment age, most of whose patients would surely have been only too glad to trade the small risk of death from anaesthesia for the horrors of the hot iron or the strong electric currents. As late as 1911, Major Pollock of the British army was still advocating the use of blisters in some cases of suspected malingering.²³ He was, however, unusual, particularly for his time, in being non-judgemental about malingerers. 'The man who for any purpose feigns disease', he wrote, 'engages in a contest of wits with the doctor, and this fact should appeal to our sporting instincts . . . We should therefore welcome the malingeringer who, as it were, takes us on a staff ride in clinical observation'.²³

However, many doctors, both civilian and military, in the 19th and early 20th centuries took a very moralistic approach, condemning malingerers as reprehensible, corrupt and detestable.²⁴ They were a bad and demoralizing influence on others. If they were successful, it encouraged others to commit the same fraud. It was therefore the duty of the doctor to be on the alert and to acquire the knowledge which was necessary to detect these miscreants

so that they could be punished and the disease stamped out. Such attitudes inevitably had an adverse effect on the doctor–patient relationship and this could be compounded by the potential conflict of interest between a doctor’s duty to his patient and his duty to either his employer or to his country which, in the case of a military surgeon, were usually one and the same. These conflicts of interest became especially relevant in cases where, as was so often the case, there was suspicion but no definite proof of malingering. Who should get the benefit of any doubt? The patient or the employer, be that a civilian employer or the army or the country. In Britain the predominant view of both civilian and military surgeons was that the benefit of any doubt should be given to the suspected malingerer.^{2,22,23} It was also the view expressed in the USA in the 1856 revision of Thomas Henderson’s *Hints on the Medical Examination of Recruits for the Army*.²⁵ And yet, in less than a decade, the American Civil War led to a dramatic reversal in opinion in that country, with the benefit of any doubt now being given not to the patient but to the army. Therefore, although Chisolm recognized that ‘it is hard to force a sick man to duty’, he seems to have accepted this as an inevitable consequence of a policy intended to ensure that most malingerers were detected.¹² Ordronaux²⁶ and Bartholow²⁷ were more explicit, writing that, if the diagnosis was uncertain, the benefit of any doubt should go not to the soldier but to the state. Keen and his colleagues agreed, arguing that if the soldier were a malingerer then no harm had been done and that if he was genuinely ill then ‘he is pretty sure to find his way into a hospital again’.¹⁴ The doctors involved in the American Civil War, both Union and Confederate, seem to have been very certain of the righteousness of their respective causes and so, in such difficult times, when manpower was often critical, they were prepared to make their duty of care to individual patients subservient to their loyalty to the cause. It may also have been easier to make a diagnosis of malingering in circumstances where the consequence was only that the soldier’s record was marked and he was returned to duty than it was in the British army where it could lead to a court martial.

An additional factor in the conflict of interests may have existed in those armies in which the combatant officers regarded the medical officers as being of inferior status, both professionally and socially.²⁸ In these circumstances the existence of malingerers reflected particularly badly on those medical officers who failed to spot them. Conversely, the enthusiastic detection of malingerers was one way in which the medical officer could demonstrate his true military attributes and his loyalty to his regiment, to his king and to his country. Such considerations may have been relevant in the epidemic of malingering which occurred in the Dutch army in the early 20th century.²⁹ It was less

likely to have been relevant during the American Civil War in which the great majority of both combatant and medical officers were in fact civilians rather than career military men. Of the doctors at Turner’s Lane Hospital, Keen had enlisted in the Army as soon as he had graduated in 1862,³⁰ but Morehouse and Mitchell, although describing themselves in their publications as ‘Acting Assistant Surgeons’ in the US Army, were, in fact, civilian contract surgeons on \$100 a month, and both retained their private practices in Philadelphia while working part-time for the Army.³¹

CONCLUSIONS

When anaesthesia was introduced as a means of detecting malingerers it was widely regarded as a major diagnostic advance. Only with the passage of time and with the subsequent advent of entirely new and previously unimagined concepts, such as hysterical conversion, did the full extent of the diagnostic pitfalls become apparent. The technique also raised various ethical issues, most notably the concept of informed consent, the judgemental and moralistic attitudes of some doctors towards their patients, and the potential for conflicts of interest in the duties of a doctor.

The pitfalls and conflicts faced by our predecessors are, with the benefit of hindsight, more obvious to us than they were to them. Similar principles apply to us and we must continually question our own practice and attitudes if we are to receive the approbation of our successors and, more importantly, of our patients.

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